

Protecting the health workers who protect our communities: reintroducing performance-based financing as a health insurance scheme for rural health workers in Sierra Leone

Swaliho Dauda Sheriff

swalihosalia@gmail.com

Ministry of Health

comment

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Abstract

Background. Sierra Leone has made substantial gains in training, recruiting, and deploying health workers nationwide. Those gains rest on a largely unprotected rural workforce. Maternal and Child Health (MCH) Aides and community health workers (CHWs) deliver much of the country's frontline primary healthcare, frequently without a salary, without formal Ministry of Health benefits, and without financial protection when they themselves fall ill.

Approach. This commentary draws on the author's experience in a district health management team and on a narrative review of published evidence on health worker motivation, retention and remuneration in low- and middle-income settings, and reviews the design, reported effects and discontinuation of Sierra Leone's national performance-based financing (PBF) scheme from 2011 to 2016. No new data were collected.

Findings. Falaba District, with a population of 166,205 recorded in 2015, has had no secondary hospital since it was created as a district and depends on 52 primary healthcare facilities staffed largely by MCH Aides working for little or no salary. Nationally, 15,000 CHWs and 1,500 peer supervisors deployed since 2017 sit outside the National Civil Service and the government payroll and receive no formal benefits. Published evidence identifies financial reward as the principal determinant of motivation and retention, and World Health Organization guidance holds that reliance on unpaid CHWs is inconsistent with the international decent work agenda. Sierra Leone's PBF scheme was reported to strengthen service delivery and to support retention in hard-to-reach areas, and its payments were perceived as a form of salary by unsalaried volunteers. The scheme ended when World Bank funding ceased in early 2016, and no successor has been implemented despite provision in the 2021 to 2025 Health Strategic Plan.

Conclusion. Reintroduce performance-based financing so a defined share of funds supports a health insurance scheme for rural health workers. Implementation should begin in the most underserved districts, be financed from domestic sources, be co-designed with health workers, and be integrated into the national health financing architecture rather than run as a donor-funded project. The benefit package, its cost, and its governance would need to be established before implementation.

Introduction

Sierra Leone has made notable progress in training, recruiting, and placing healthcare workers across various cadres nationwide. Sustaining that progress requires more than increasing workforce numbers. It also requires improving the conditions under which health workers serve, particularly those working in rural communities.

Health system performance rests on several interacting functions, and the workforce sits at their centre. A country needs enough trained, skilled, motivated, and equitably distributed health workers if its services are to function. In Sierra Leone, the cadres that carry the largest share of rural primary care, chiefly Maternal and Child Health (MCH) Aides and community health workers (CHWs), often work for

little or no pay and under poor conditions, which weakens service delivery in the districts that can least absorb it.

Between 2011 and 2016, Sierra Leone implemented a national performance-based financing (PBF) scheme that was reported to strengthen service delivery and support staff retention in hard-to-reach areas. For unsalaried volunteers, those payments were often viewed as a form of salary and, in many cases, served as a crucial source of support. The scheme ended when World Bank funding ended in early 2016, and no replacement has been introduced since (1, 2).

This paper sets out the case for restoring performance-based financing, redesigned as a health insurance scheme for rural health workers. It describes the scale of the protection gap, reviews the evidence linking remuneration to motivation and retention, examines what the 2011 scheme achieved and why it ended, and presents three policy options with a recommended course of action. It is a commentary rather than a systematic review, and the evidence cited was assembled narratively in support of a policy argument.

The problem: a workforce hidden beneath the national numbers

The rural reality behind the national averages

Falaba District, whose population was recorded as 166,205 at the 2015 national Population and Housing Census, has had no secondary hospital since its creation as a district. The district relies on 52 primary healthcare facilities, many of which are staffed by MCH Aides who often work for little or no salary and under difficult conditions.

A systemic pattern, not a local exception

Sierra Leone's health workforce remains heavily concentrated in the Western Area. Beyond that region, higher-level professional cadres are extremely limited, making the health system dependent on MCH Aides for reproductive, maternal and newborn healthcare services (3). The national community health worker programme, introduced in 2017, includes about 15,000 CHWs and 1,500 peer supervisors based around Peripheral Health Units, with each covering catchment areas of seven to ten villages (4). However, evidence from Sierra Leone shows that these cadres are not part of the National Civil Service, are not on the government payroll, receive no formal Ministry of Health benefits, and remain highly dependent on donor funding (5). This challenge sits within a broader global health workforce crisis: a long-standing WHO estimate, reported in the literature on rural retention, puts the shortage at 2.4 million doctors, nurses and midwives across 57 countries, 36 of them in Africa (6).

Table 1
The problem in figures.

Figure	What it represents
166,205+	Falaba District, recorded at the 2015 National Population and Housing Census.
0	Secondary hospitals in Falaba District since its creation.
52	Primary healthcare facilities the district relies on, mostly staffed by MCH Aides who often work for little or no salary.
15,000 + 1,500	CHWs and peer supervisors deployed under the national community health worker programme established in 2017, who are not part of the National Civil Service or on the payroll.
2.4 million	Deficit of doctors, nurses and midwives across 57 countries, 36 of them in Africa, according to a long-standing WHO estimate.

MCH, Maternal and Child Health; CHW, community health worker; WHO, World Health Organization.

Why this matters: motivation and universal health coverage

Training and hiring health workers will not, by themselves, achieve quality, accessible and affordable healthcare for all, commonly referred to as universal health coverage (UHC). To reach that goal, health workers must be genuinely motivated through better working conditions.

Motivation and retention are closely connected

A systematic review of studies from developing countries identified financial rewards as one of seven major motivators. It also found that poor salaries are especially demotivating because they make health workers feel undervalued (7). In a cross-sectional study in Ghana, 69% of surveyed health workers reported an intention to leave their jobs, while higher motivation and job satisfaction were associated with lower turnover intention (motivation OR = 0.74, 95% CI 0.60--0.92; job satisfaction OR = 0.74, 95% CI 0.57--0.96) (8). In resource-limited settings, retaining and motivating health workers requires continued investment in workforce planning, development, and financing, often through combined incentive packages, since no single global model works everywhere (9). Non-financial incentives, including recognition, supportive human resource management, and adequate supplies, are also essential complements to financial compensation (7, 10).

Global guidance is clear on remuneration

The 2018 WHO guidelines on health policy and system support for community health workers programmes recommend that practising CHWs receive a financial package reflecting the demands, complexity, working hours, and responsibilities of their role, a position restated in a recent review of labour conditions in these programmes(11). WHO guidance also states that relying on unpaid CHWs is

inconsistent with the international decent work agenda, and that non-monetary incentives, while valuable, cannot replace financial remuneration (12). When such support is missing, inadequate incentives have been associated with high turnover in large-scale community health worker programmes, weakening a workforce considered essential for achieving UHC (13).

What supported programmes have achieved

Positive outcomes in community health worker programmes are supported by factors such as community embeddedness, supportive supervision, continuous education and adequate logistical support (14). In rural Liberia, a pilot CHW programme was associated with increased use of child and maternal health services from formal providers in remote areas (15). In Ghana, the large-scale Community-based Health Planning and Services programme, in which salaried community health officers provide care from community compounds, was implemented alongside national declines in under-five mortality from 108 per 1,000 live births to 80 per 1,000 live births, and a reduction in total fertility from 4.6 to 4.0 children per woman between 1998 and 2008 (16). These are national trends over a decade of scale-up and cannot be attributed to the programme alone.

What Sierra Leone has already tried: the PBF scheme of 2011 to 2016

Table 2
Design and discontinuation of Sierra Leone's 2011 performance-based financing scheme.

Feature	Design as implemented
Launch	Introduced nationwide in primary healthcare facilities in 2011 by the Ministry of Health.
Purpose	Designed to complement salary increases that followed the 2010 Free Health Care Initiative, with bonuses shared between facilities and staff.
40% of funding	Flexible facility-level funding intended to replace lost user revenues.
60% of funding	Direct staff incentives linked to the delivery of priority services.
Remote allowance	Added in January 2012 to encourage staff to accept postings in more rural and hard-to-serve areas.
End of scheme	Continued only until World Bank funding ended in early 2016.
Status today	The 2021 to 2025 Health Strategic Plan calls for the introduction of a new PBF scheme, but none has been launched to date.

PBF, performance-based financing. Source: references (1, 2).

What the scheme achieved

Performance-based financing was reported to improve service delivery and support staff retention, especially in hard-to-reach areas. Research from rural Sierra Leone found that PBF payments made a meaningful contribution to health workers' overall income. The payments were widely perceived as a form of salary, especially by unsalaried volunteers, for whom they often acted as a lifeline (1, 2).

Why did the scheme end?

The national PBF scheme lasted only until World Bank funding ended in early 2016. Discussions about extending it were overtaken by the post-Ebola political shift toward infectious disease control and Presidential Recovery Priorities, which did not include health financing or PBF (1). Although the 2021 to 2025 Health Strategic Plan mentions introducing a new PBF scheme, no such scheme has been implemented to date (2). Since then, unsalaried health workers, the same cadres on which rural primary healthcare depends, have been left without the payments that had served as their de facto income (2).

The cost of an unprotected workforce

The human cost of this protection gap is serious. Health workers who become seriously ill while serving their communities may be unable to meet the cost of treatment for treatable conditions.

This is a foreseeable consequence of weak financial protection. Across 40 low- and middle-income countries, an average of 25.9% of households borrowed money or sold assets to pay for healthcare, with the risk being higher among the poorest households and in countries with less health insurance coverage (17). In 2018, out-of-pocket spending accounted for nearly 40% of current health expenditures in low- and middle-income countries, exposing millions of families to catastrophic health spending (18). Health workers are not protected from these pressures. A survey of the Ugandan health workforce reported dissatisfaction with jobs, particularly with compensation and working conditions, and identified salary and benefits, especially health coverage, as policy tools for strengthening the workforce (19).

Pay, working conditions, and protection against illness are not merely employment benefits. They influence whether trained workers remain in their posts, perform effectively, and continue to serve the communities that rely on them (7, 8).

Policy options

Three policy options are set out in Table 3. They are not mutually exclusive: Options 2 and 3 can be implemented alongside the recommended Option 1.

Table 3
Policy options for protecting rural health workers in Sierra Leone.

Option	What it involves	Evidence base
Option 1 (recommended): revive PBF as a health insurance scheme for rural health workers	Reintroduce performance-based financing, structured so that a defined share of funds goes into a health insurance scheme for rural health workers. The scheme should cover premiums, co-payments, and benefits in a way that prevents illness in the line of duty from leading to financial ruin or preventable death. This option builds directly on Sierra Leone's own experience of what has worked.	(1, 2)
Option 2: extend health insurance coverage to all rural health workers, including unsalaried MCH Aides	Formalise MCH Aides and other community-based cadres by integrating them into payroll and benefit systems, consistent with WHO guidance on remuneration that reflects job demands and with evidence that these workers currently receive no formal benefits.	(3, 5, 11, 12)
Option 3: combine financial and non-financial incentives	Link pay and insurance with non-financial retention measures, including career development, recognition, supervision, and dependable supplies, because evidence shows that financial incentives alone are insufficient.	(7, 10, 20)

PBF, performance-based financing; MCH, Maternal and Child Health; WHO, World Health Organization.

Recommendation and next steps

The Ministry of Health should revive performance-based financing, this time as a health insurance scheme for rural health workers. Implementation should:

- Prioritise the most underserved districts first, beginning with Falaba, where 166,205 people recorded at the 2015 census depend on 52 primary healthcare facilities staffed largely by unsalaried MCH Aides.
- Secure sustainable domestic financing, drawing lessons from the 2016 collapse that followed the end of donor funding (1).
- Design the insurance package with health workers themselves, so that the benefits respond to the real risks they face while performing their duties. The contents of the package, its cost per worker and the source of the premium will need to be established before any scheme is launched.
- Integrate the scheme into the national health financing architecture, treating CHW remuneration as a health financing function within the health system rather than as a donor-funded project (21).

Limitations

This is a commentary and not a systematic review. The published evidence was selected to support a policy argument rather than identified through a protocol-driven search, so work reaching different

conclusions about performance-based financing may be underrepresented. Evaluations of performance-based financing in other low-income settings have not always found benefits, and that literature is not reviewed here in full.

The district material is drawn from the author's professional experience within one district health management team and was not collected or analysed as research data, so it should be read as context rather than as evidence. The proposal is set out in principle only: no costing, benefit package, actuarial assessment, or government model is presented, and each would be required before implementation.

Conclusion

Sierra Leone's achievements in training and deploying health workers are real, but they remain fragile. When rural health workers are unpaid, unprotected, and unable to afford treatment for their own illnesses, the goal of universal health coverage will remain out of reach. Experience elsewhere in West Africa points the same way: community-based cadres require sustained policy attention if the gains they deliver are to be maintained (22). Sierra Leone has already shown, through its PBF scheme, that financial incentives can improve service delivery and help retain staff in hard-to-reach areas (1). Reviving that principle through health insurance for rural health workers is a practical next step: those who protect our health deserve to have their own health protected.

Declarations

Ethics approval and consent to participate. Not applicable. This analysis used only published literature and publicly available programme and census data, together with the author's professional experience within a district health management team; no human participants were involved.

Consent for publication. Not applicable.

Availability of data and materials. No new data were generated. All sources supporting the analysis are cited in the reference list and are publicly available.

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